This final decision is issued by me, Richard West, an Ombudsman with the Financial Ombudsman Service.

My colleague, Ombudsman Graham Booth, issued a Provisional Decision on 30 June 2017 ("the Provisional Decision") explaining that he was not minded to uphold the complaint and setting out his reasons for reaching those provisional conclusions.

As the parties are aware, the complaint has now been passed to me to determine. I wrote to the parties on 9 August 2017 explaining that:

- Having considered the evidence and arguments presented by the parties prior to the Provisional Decision, I was minded to reach the same conclusions as Ombudsman Booth provisionally reached about what is fair and reasonable in the circumstances of Mr F's complaint and for the same reasons.

- In the circumstances and subject to any further evidence and representations submitted by the parties since the Provisional Decision, I was minded to determine the complaint and issue a final decision in the terms set out in the Provisional Decision.

- I would consider the parties' further representations (together with the evidence and arguments submitted before the Provisional Decision) before reaching my final decision.

Both parties made further submissions, all of which I have considered carefully. This is my final decision on Mr F's complaint.

summary

1. This dispute is about the sale in 1998 of a payment protection insurance (PPI) policy to support the firm's credit card.

2. Mr F complains that the firm did not properly explain the policy's features, exclusions and limitations. If it had, he says he would not have taken the policy out.

3. The firm considers the sale met the standards expected of it at the time. But in any event, it says, Mr F would have taken out the policy even if it had given him clearer information, so it does not think he lost out.

4. I have carefully considered all of the evidence and arguments submitted by both sides, in order to decide what is, in my opinion, fair and reasonable in all the circumstances of this complaint.

5. This is not a straightforward complaint, with both parties making credible arguments in support of their positions. But for the reasons I explain in detail below, I have decided to determine the complaint in favour of the firm, to the extent that I have not made an award in favour of Mr F.

6. This is my final decision. In summary, having considered all of the evidence and arguments submitted by the parties during the course of the complaint, my final conclusions are as follows:

   - Mr F made his decision to take out the policy based on the information the firm gave him about the policy.

   - Taking into account the law, industry codes of practice and what I consider to have been good practice in 1998 (there were no applicable regulations at the time), the firm should fairly and reasonably have provided Mr F with sufficient clear, fair and not misleading information about the policy it was offering to enable him to make an informed decision about whether to take it out.

   - The firm did not act fairly and reasonably in its dealings with Mr F. The firm did not provide Mr F with sufficient information about the costs, benefits, exclusions and limitations affecting the cover in a clear, fair and not misleading way to enable Mr F to make an informed choice about whether to take out the policy.

   - Mr F made his decision to take out the policy based on incomplete and inaccurate information. But if things had happened as they should, on the evidence available in this case, it is more likely than not Mr F would still have taken out the policy.

   - It would not be fair in those circumstances to make an award to compensate Mr F for the money he spent in connection with the policy.

7. Under the rules of the Financial Ombudsman Service, I am required to ask Mr F either to accept or reject my decision before 9 October 2017.

background to the complaint

a) events leading up to the complaint

8. In the final days of 1998, Mr F applied for the firm's credit card. He completed an application form – called a 'Priority Request Form'– requesting both the card and 'Payment Protection Cover'.

9. The firm processed the application in early January 1999 and Mr F made the first transaction, a £2,000 balance transfer to the account, on 19 January.

10. Thereafter, the firm's transaction report for the account shows he used the card occasionally, making quite large cash withdrawals and a small number of purchases. His balance increased steadily reaching £4,000 in March 2001. At that point he repaid the balance in full, before running the balance up to around £7,500 by early 2003, when he again paid off the balance in full.

11. Along the way he made monthly payments to the account by cheque (usually between £60 and £80 per month), except for on four occasions when he missed payments.

12. Mr F did not use the card after March 2003 and eventually, in June 2006, the firm closed the account.

b) Mr F's circumstances in 1998

13. The Priority Request Form Mr F completed contains some information about his circumstances at the time. He was a 56-year old, married, homeowner with a mortgage. He was employed as an HGV driver earning £15,600 per year, with a total household income of £23,600. He had two other credit cards.

14. Separately, Mr F has told us that:

- He had worked for his employer for 18 years when he applied for the card.
- He would have received less than three months' pay if he was off work due to sickness or accident or redundancy.
- He would not have had any other way of making his card repayments if he wasn't able to work.

15. I note, for the sake of completeness, in the early stages of his complaint, Mr F also told us that he was entitled to 'full sick pay'. He subsequently clarified – through his representative – he meant he was entitled to full pay for less than three months if he was off work due to sickness.

16. Most recently, in his response to the Provisional Decision Mr F 's representative said – in passing – he would have received three months' sick pay. I shall address in greater detail the inconsistencies in Mr F's recollections later on in this decision. But in relation to his sick pay entitlement, on balance I think it's more likely than not that Mr F was, as he said in his earlier representations, entitled to less than three months' sick pay.

17. Whilst I note Mr F's representations about redundancy, I think it is likely he would have been in a slightly better position than he has suggested if he were made redundant.

18. The statutory redundancy provisions that applied at the time meant he would have been entitled to 1.5 weeks' pay for each year of employment in which he was 41 or over and a week's pay for each year of employment when he was between the ages of 22 and 40.

19. In Mr F's case that would equate to a statutory right to nearly six months' pay from his employer were he made redundant. I accept, however, his representations that he would receive less than three months' pay if he were unable to work through accident or sickness and that he had no other means of making his credit payments in those circumstances.

c) the policy – what was the firm selling and what did Mr F buy?

20. There is some doubt about the steps Mr F followed when applying for the card and policy and the paperwork he received, which I shall address later on. But the firm has provided a copy of the full policy terms and conditions it says – and which I accept on the balance of probabilities – applied to policies like Mr F's.

21. The terms and conditions were set out in a two page 'Payment Protection Cover Certificate of Insurance' document. Among other things, these show that:

- There were eligibility criteria which Mr F met – for example he had to be 18 or over, but less than 65 and working at the start date. The cover would end when he reached 65.

- The policy provided life cover – it would pay off the amount Mr F owed on his card in the event of his death up to a maximum of £15,000.

- The policy provided disability cover. Broadly, if Mr F was unable to carry out the duties of his work (or any other work which in the insurer's view he might reasonably do in view of his training, education and ability) due to injury, sickness or disease, it would pay a fixed amount (usually equal to 3% of the outstanding balance at the start of the claim), each month, until the disability came to an end, or until the outstanding balance at the start of the disability was cleared.

- The policy would provide unemployment benefits. Broadly, the policy would pay a fixed amount (usually equal to 3% of the outstanding balance at the point Mr F knew he would become unemployed), each month, until Mr F ceased to be unemployed, the outstanding balance at the start of the claim was repaid, or Mr F had received twelve payments, whichever came first.

- There were two insurers – Insurer A provided the life cover and Insurer B provided the disability and unemployment cover.

22. To put the benefit payments into context, I have calculated roughly what would happen to Mr F's account, assuming he made a successful claim for 12 months after spending £3,000 on his card on purchases.

23. The calculation assumes: a 1.53% per month interest rate (the rate the firm charged on purchases), the PPI cost 68p per £100 of balance and that the minimum payment was 2% of the monthly balance (as the card conditions suggest was the case).

24. It shows that during the 12-month period of the claim, the policy would more than cover the contractual monthly minimum payment and would reduce the outstanding account balance by more than £300.

Month	Opening balance	Spend	PPI premium	Interest	Insurance payment	Closing balance	Minimum payment
1	£0	£3,000.00	£0	£0	£0	£3,000.00	£0.00
2	£3,000.00	£0	£20.10	£45.90	£90.00	£2,976.00	£60.00
3	£2,976.00	£0	£19.93	£45.53	£90.00	£2,951.47	£59.52
4	£2,951.47	£0	£19.77	£45.16	£90.00	£2,926.39	£59.03
5	£2,926.39	£0	£19.59	£44.77	£90.00	£2,900.76	£58.53
6	£2,900.76	£0	£19.41	£44.38	£90.00	£2,874.55	£58.02
7	£2,874.55	£0	£19.23	£43.98	£90.00	£2,847.77	£57.49
8	£2,847.77	£0	£19.05	£43.57	£90.00	£2,820.39	£56.96
9	£2,820.39	£0	£18.86	£43.15	£90.00	£2,792.40	£56.41
10	£2,792.40	£0	£18.67	£42.72	£90.00	£2,763.79	£55.85
11	£2,763.79	£0	£18.47	£42.29	£90.00	£2,734.54	£55.28
12	£2,734.54	£0	£18.27	£41.84	£90.00	£2,704.65	£54.69
13	£2,704.65	£0	£18.06	£41.38	£90.00	£2,674.09	£54.09

25. Returning to the policy terms and conditions, there were also exclusions – for example, claims resulting from pre-existing medical conditions which Mr F knew, or should have known about, weren't covered.

26. There were also limitations restricting the circumstances in which a successful claim could be made, for example:

- The policy would cover Mr F if he was unable to work because of a mental or nervous disorder, including stress or stress-related conditions, but only if it was diagnosed by, and required a continued course of treatment by a specialist. A 'specialist' meant a *'Doctor who holds or has held a Consultant Psychiatrists appointment at a NHS hospital'*.

- The policy would cover Mr F if he was unable to work because of a back condition, but only if Mr F were to supply radiological evidence of medical abnormality from a Doctor.

27. It is also of note that condition 12 (headed *'Association of British Insurers' Code of Practice'*) contains information about the firm's status when selling the policy:

This insurance has been arranged by the Bank [the firm] *as Our* [the relevant insurer depending on the type of cover] *agent for whom We accept responsibility. The Bank has undertaken to comply with the Association of British Insurers Code of Practice for the Selling of General Insurance. A copy of the Code of Practice is available for inspection on request.*

d) the complaint and the firm's response

28. Mr F's representatives made lengthy and substantial representations on his behalf, prior to the Provisional Decision, particularly during the later stages of the complaint.

29. I will not restate them all here and I will refer to some of the specific representations he has made at relevant times in this decision. But I have read and considered them all carefully. In essence, Mr F says:

- The firm did not give him the information it should have given him about the costs and benefits associated with the policy. The only information it gave him was on the Priority Request Form. That information was incomplete and misleading.

- It was not enough to say the premium was 68p per £100 of outstanding balance as the firm did. The true costs were much higher as the premiums were added to the account attracting interest (which compounded over time) and the premiums would continue to be charged during the period of a successful claim, reducing the benefit. This meant the policy was both expensive and represented exceptionally poor value.

- The firm did not tell him about the poor value of the policy, which is illustrated by the low claims ratio – for example in 2011, less than 20p in every pound was used to pay claims, the rest paid for costs, profits and commission. The firm's failure to explain this to him was a breach of the common law duty of utmost good faith.

- The firm did not tell him about the limitations affecting the policy, in particular: that the policy would only pay out if he was unable to do both his own job and other work which the insurer thought he was reasonably qualified to do; and that claims arising from back injury and mental health were subject to restrictions and evidential requirements which significantly reduced the cover provided by the policy and the prospects of making a successful claim. This reduced further the policy's value, particularly as those conditions are the cause of the most common reasons for long term absence.

- The common law duty of utmost good faith meant the firm should have done more than simply draw the limitations to his attention, it should also have explained the significance of them and the affect they would have on his chances of making a claim.

- The information he received was misleading because it gave him the impression that it would protect his payments indefinitely (which was not the case) without mentioning the true costs and the limitations. The firm told him the policy offered *'valuable, low cost, peace of mind'* – that was not true and amounted to a misrepresentation.

- These were substantial flaws in the sale process. Had he known the true cost of the policy, the limits on the cover and its poor value, he would not have taken it out – that would have been the logical outcome, given the seriousness of the failings.

- In any event, FCA's guidance at DISP App 3.6.2E makes it clear that it should be presumed he wouldn't have taken out the policy unless there is evidence to outweigh the presumption. I am required to take that regulatory guidance into account when deciding what is fair and reasonable and should not depart from it, other than in exceptional circumstances when there is sufficiently good reason to take a different approach.

- The firm should pay compensation to put him in the position he would have been in if he had not taken out the policy.

30. The firm's legal advisor also made substantial representations prior to the Provisional Decision. Again I won't restate them all, but I have read and considered them carefully. In essence the firm said:

- It was not subject to any legally binding codes of practice in 1998, but it did try to comply with the ABI Code of Practice for intermediaries, which provided high level principles about information provision. The expectations on businesses were different in 1998 to what they are now and it should not be judged by more recent standards.

- Nor would it be fair and reasonable to hold it responsible in circumstances that would not also have amounted to a breach of the law. It had not joined the Banking Ombudsman Scheme at the time (although the Banking Ombudsman could have considered the complaint once it had joined), so it could not have predicted at the time of sale that it might be held liable even though it had not breached the law.

- Mr F applied for his credit card by direct mail. Owing to the passage of time, it cannot now be certain exactly what information it gave him.

- But it is likely the application pack Mr F received contained information about the policy in the Credit Card Terms and Conditions leaflet and there may have been other letters. He would also have been sent the full policy conditions – in accordance with its standard process – after he took out the card.

- It was not under a legal obligation to provide more information than that. It did not have to provide the level of information Mr F has suggested and the information he received was not misleading. Nor was the information it provided, or anything else it did, contrary to standards of good practice at the time. Neither the Banking Ombudsman nor a court would have upheld Mr F's complaint if it had been brought in 1999.

- Even if it did not do enough, on the balance of probabilities, Mr F would still have taken out the policy and there is sufficient evidence to rebut the presumption set out in the FCA's guidance for firms at DISP App 3 that he would not have taken out the policy.

e) the parties' representations in response to the Provisional Decision

31. Both parties made further representations in response to the Provisional Decision, all of which I have read and considered carefully. The parties, in large part, restated the substance of their prior representations.

32. I will refer to some of the specific representations made at relevant times in this decision, but, briefly and in summary, Mr F says:

- The Provisional Decision fails to properly deal with matters raised in earlier correspondence.

- The Priority Request Form gave the false impression that there was no limit to the period of cover; that it would cover any form of illness when there were

extremely onerous limitations; and that the policy offered *"valuable, low cost peace of mind"*.

- The Provisional Decision fails to take into account the true cost of the policy in light of the interest the premiums would attract, ignores the fact it was very unlikely that he could make a successful claim and does not acknowledge the poor value of the policy shown by the claims ratio.

- The Provisional Decision concludes that the sale was made on a 'non-advised' basis, but the selective information the firm provided and the statements it made about the policy's value amounted to advice (taking into account the FCA's perimeter guidance – PERG 5.8.9 and 5.8.11). It would be wrong to conclude otherwise given the firm said in 2003 that it *'recommended payment protection insurance to all our customers'*.

- The Provisional Decision fails to properly take into account the fact that the Priority Request Form misrepresented the cost of the policy, the value of the policy and the protection afforded by the policy. The Provisional Decision fails to properly take into account how a court would view those misrepresentations and the approach it would take when determining the remedy.

- The firm was under duties to treat its customers fairly, to provide them with full and fair information and not to take advantage of a customer's inexperience. The firm breached those duties through its statements and failure to disclose the exclusions, limitations, true costs, poor value and commission.

- The Provisional Decision does not properly take into account the FCA's guidance at DISP App 3.6.2, misconstrues the tests the guidance sets out and fails to properly assess and weigh up the evidence in the complaint.

- Even if it were appropriate to approach DISP App 3.6.2 in the way suggested in the Provisional Decision, no reasonably prudent consumer *'who had uncovered the truth about PPI'* would have taken it out.

33. Briefly and in summary the firm says:

- It agrees with the overall conclusions drawn in the Provisional Decision.

- Owing to the passage of time, it's not now possible to know with certainty what documents Mr F received. It's possible he might have used an old application form containing different information.

- It agrees that the ABI publications referred to in the Provisional Decision are relevant considerations in this case, but they are not determinative of its liabilities. A court might take them into account when determining whether there has been a common law breach of a duty of care, but the ABI publications do not have the status of binding obligations owed to Mr F as if they were FCA rules and the undertaking the firm gave to the insurers (to comply with the ABI Code) does not change that.

- The overarching questions set out in the Provisional Decision appear to include wording and expectations derived from irrelevant considerations such as the FCA's principles. It would be helpful if I could clarify which of the standards I rely on for my final conclusions and the source.

- The Provisional Decision set out what in the Ombudsman's view the firm should and should not have done. It would be helpful I were to explain what I think the legal consequences are and whether those breaches amounted to an actionable legal breach making the firm legally liable.

- Its view is that there were no actionable legal breaches - it provided Mr F with the information it was required to provide as a matter of law, it did not owe him a legal duty to point out that he ought to read the terms and conditions of the policy, and the ABI publications did not create any additional legal duty.

- As there were no actionable breaches it would be difficult for me to reach a different conclusion to the conclusion a court might reach on the basis that it is fair and reasonable to do so – the sorts of considerations that are relevant to whether or not there has been an actionable breach of a legal duty of care will normally lead to a fair and reasonable result.

34. Both Mr F and the firm have explained why they do not accept the other's further representations. Whilst I do not consider it necessary to set out or repeat why that is the case, given the summary of the parties' representations I have already included above, I have considered all of their representations carefully.

my findings

35. Although I have only included a summary of the complaint, I have read and considered all the evidence and arguments available to me from the outset, in order to decide what is, in my opinion, fair and reasonable in all the circumstances of the case.

a) relevant considerations

36. When considering what is fair and reasonable, I am required to take into account: relevant law and regulations; relevant regulators' rules, guidance and standards; relevant codes of practice; and, where appropriate, what I consider to have been good industry practice at the time.

37. This sale took place in 1998 before the General Insurance Standards Council (GISC) published its code of practice in June 2000 and before the sale of general insurance products like this became regulated in January 2005. So the GISC code, the FSA's (and FCA's) overarching Principles for Businesses and insurance conduct rules (ICOB and ICOBS) aren't applicable to this complaint, nor is the FCA's Perimeter Guidance (PERG) that Mr F has referred to in response to the Provisional Decision.

38. The credit agreement itself concluded in 2006. That means the unfair relationship provisions set out at s140A of the Consumer Credit Act, the Supreme Court judgment in *Plevin*[1] about s140A of that Act and the rules and guidance made by the FCA recently about the handling of complaints about the non-disclosure of commission in the light of the *Plevin* judgment, aren't applicable either.

39. But there were a number of industry codes in existence at the time, which I am satisfied are applicable to my consideration of what is fair and reasonable in the circumstances of this complaint. In particular:

The Association of British Insurers' General Insurance Business Code of Practice for all intermediaries (including Employees of Insurance Companies) other than Registered Insurance Brokers' – 'The ABI Code'

40. First introduced in 1989 and updated in March 1996, the ABI Code set out a framework of general principles within which ABI members and intermediaries were expected to sell general insurance, including payment protection policies like this. Among other things it said, that:

- *'It shall be an overriding obligation of an intermediary at all times to conduct business with utmost good faith and integrity.'*

- The intermediary should:

  - *'ensure as far as possible that the policy proposed is suitable to the needs and resources of the prospective policyholder.'*

  - *'explain all the essential provisions of the cover afforded by the policy, or policies, which he is recommending, so as to ensure as far as possible that the prospective policyholder understands what he is buying.'*

  - *'draw attention to any restrictions and exclusions applying to the policy.'*

Guidance on the application of the ABI Code

41. The ABI also issued guidance to member companies on the application of the ABI code and a note summarising the main points of that guidance.

42. The 'Guidance Notes for Intermediaries' issued in December 1994 included:

When selling insurance intermediaries must

...2.5 Explain the essential provisions of the insurance cover, draw attention to any restrictions and exclusions under it, as well as the consequences of non-disclosure…

…2.13 If an independent intermediary, disclose commission on request…

43. The 'Resume for Intermediaries' published in July 1999 – shortly after the sale of Mr F's policy, but relating to the ABI Code in place at the time of sale – explained how insurers should interpret some of the key requirements of the ABI Code including:

[1] *Plevin v Paragon Personal Finance Limited [2014] UKSC 61*

"Explain all the essential provisions"
It is necessary for the intermediary (insurer, if dealing direct) to provide an overview of the policy. The detail will vary depending on the particular class of insurance. However, the proposer should have a reasonable understanding of what he is buying, whether this is explained orally or whether he is given a summary and his attention drawn to the main points. In this respect, it is important to recognise the responsibility under the ABI Statement of General Insurance Practice that insurers will work towards clearer policy wordings.

The intermediary is not expected to go through all the provisions and exclusions in detail. The important feature is to identify the level of cover being provided (for example, in the case of household contents whether it is "indemnity" or "new for old"), that the type of policy being sold suits the circumstances of the proposer and the level of protection they are seeking as far as possible. It is not good enough simply to offer, for example, an indemnity basis of cover without explaining the limitations and, indeed, that other options are available, unless, of course, the proposer wittingly asks for that type of cover.

"Draw attention to any restrictions and exclusions"
The same general principles outlined above apply equally here. Certain exclusions, conditions, restrictions etc under a particular policy will be common to all policyholders, for example, a condition about fraud. In those circumstances, it would not be necessary to identify these other than by reference to general exclusions applying to all policyholders of a particular type of insurance, either orally or in policyholder documentation.

However, some will be more relevant and, indeed, significant to certain but not other policyholders. An example would be where benefit to self-employed people is either excluded or severely restricted for redundancy cover under a creditor insurance policy. Clearly, self-employed people should be made aware of this so they can decide whether the other benefits under the policy and the premium to be paid justifies taking out such a policy.

The ABI Statement of Practice for Payment Protection Insurance

44. The ABI also published a statement in December 1996 about PPI. Among other things, it said:

Providers will give sufficient detail of the essential provisions of the cover afforded by the policy so as to ensure, as far as is possible, that the prospective insured person understands what he/she is buying.

In particular:

the suitability of a contract will be explained to those who are self-employed, those on contract or part time work, and those with pre-existing medical conditions;

details of the main features of the cover as well as important and relevant restrictions will be made available and highlighted at the time the insurance is taken out with full details being sent afterwards;

all written material will be clear and not misleading;

full details of the cover will be provided as soon as possible after completion of the contract.

The ABI General Business Code of Practice for Telephone Sales, Direct Marketing/Direct Mail and the Internet

45. This code published in June 1997 explained that the original ABI Code was intended to relate principally to face-to-face selling, so this focused on remote selling methods and was to be read in conjunction with the main ABI Code.

46. It said that in direct marketing and direct mail cases where the advertisement or mailshot is accompanied by an application form giving the individual the opportunity to commit himself to the insurance, ABI Code compliance required:

…

(i) a summary of cover highlighting the main provisions, restrictions and exclusions should be provided…"

47. The firm was not a member of the ABI, so it was not itself directly subject to the codes, but it had undertaken to follow the ABI Code as the Certificate of Insurance noted. Even if that were not the case (and I note the firm's comments that this was an undertaking made to the insurer not to Mr F), I consider the ABI Code to have been indicative of standards of good practice for those, like the firm, offering or selling insurance to consumers in 1998.

48. The importance of the ABI Code in 1998 can be seen from the expectations at the time. As the Resume for Intermediaries I referred to at paragraph 43 explained,

The Code is mandatory for business sold by ABI members in the UK. The DTI are responsible for ensuring that companies which are not members of ABI comply with the Code and, in addition, bringing the Code to the attention of foreign insurance companies covering UK risks on a services basis as part of the UK's general good rules'.

49. The Resume for Intermediaries was published in July 1999, but the status of the ABI Code and compliance arrangements it described were the same when Mr F took out his policy in late 1998.[2] The ABI was responsible for making sure that member insurers followed the ABI Code, the Department of Trade and Industry was responsible for making sure that non-member insurers complied with the ABI Code and the ABI Code itself required those insurers to use their *'best endeavours to ensure that all*

[2] See for example the House of Commons Library Research Paper 95/129 *Financial Services: Regulators and Ombudsman* published on 13 December 1995 which said at page 8:

> *'The ABI's Code of Practice for the selling of General Insurance, which aims to ensure the terms of contracts and the status of intermediaries are clear to consumers, is mandatory for ABI members. The Department of Trade and Industry is responsible for seeing that the terms of the Code are observed by non-ABI members.'*

those involved in selling their policies observe its provisions' – hence the undertaking the firm gave.

50. The other codes supplemented the ABI Code and I also consider them to be indicative of the standards of good practice expected of intermediaries like the firm at the time.

51. So I am satisfied I should take the ABI Code and the other codes into account when deciding what is, in my opinion, fair and reasonable in the circumstances of Mr F's case.

52. Whilst I note the firm's representations about the status of the various ABI publications, I am satisfied they are relevant considerations in their own right to be taken into account when deciding what is in my opinion fair and reasonable (either as relevant codes of practice, or as indicators of good practice), and not just to the extent that a court might take them into account when considering the existence or standard of a common law duty of care.

The law

53. I have also taken account of the law, including: the law relating to negligence, misrepresentation and contract (including the express and implied duty on professional advisers to give advice with reasonable skill, care and diligence); the law relating to the duty of utmost good faith; and the law relating to causation and remoteness.

54. I have considered carefully the parties' representations about the law set out in a number of documents including most recently the firm's legal advisors letters of 14 March 2017, 1 August 2017 and 23 August 2017 and the representative's letters of 31 March 2017, 31 July 2017 and 21 August 2017 in relation to Mr F's complaint and its letters to this office about complaints generally dated 2 March and 5 June 2017.

The approach taken by former schemes

55. Under the transitional provisions[3] which continue to apply to complaints like this about acts or omissions before 1 December 2001, I am also required to take into account what determination the relevant former scheme – in this case the Office of the Banking Ombudsman – might have been expected to reach in relation to an equivalent complaint.

56. In that respect, I note that, among other things, under the Banking Ombudsman's terms of reference:

- The Ombudsman was required to decide complaints by reference to what was, in his opinion fair in all the circumstances.

- The Ombudsman was required to observe any applicable rule of law or relevant judicial authority.

[3] The Financial Services and Markets Act 2000 (Transitional Provisions) (Ombudsman Scheme and Complaints Scheme) Order 2001 (SI 2001/2326)

- The Ombudsman was required to have regard to the general principles of good banking practice and any *'relevant code of practice applicable to the subject matter of the complaint'*.

- The Ombudsman could make money awards, but *'no award shall be of a greater amount than in the opinion of the Ombudsman is appropriate to compensate the complainant for loss or damage or inconvenience suffered by him by reason of the acts or omissions of the Bank against which the award is made'*.

The FCA's guidance for firms Handling PPI complaints – DISP App 3

57. I am also mindful of the evidential provisions and guidance set out at DISP App 3, first issued by the FSA in 2010, which sets out how firms should handle complaints relating to the sale of payment protection contracts like Mr F's.

58. The sale took place before insurance mediation became a regulated activity in January 2005, so the firm was required to take into account the evidential provisions in DISP App 3 as if they were guidance when considering Mr F's complaint.

59. I note DISP App 3 includes guidance for firms about assessing a complaint in order to establish whether the firm's conduct of the sale fell short of the regulatory and legal standards expected at the time of sale – referred to as 'breaches or failings'. It did not impose new, retrospective, expectations about selling standards.

60. DISP App 3 also contains guidance for firms about determining the way the complainant would have acted if a breach or failing by the firm had not occurred. In relation to that it says:

DISP App 3.1.3G
Where the firm determines that there was a breach or failing, the firm should consider whether the complainant would have bought the payment protection contract in the absence of that breach or failing. This appendix establishes presumptions for the firm to apply about how the complainant would have acted if there had instead been no breach or failing by the firm. The presumptions are:

> *(1) for some breaches or failings (see DISP App 3.6.2 E), the firm should presume that the complainant would not have bought the payment protection contract he bought; and*
>
> *(2) for certain of those breaches or failings (see DISP App 3.7.7 E), where the complainant bought a single premium payment protection contract, the firm may presume that the complainant would have bought a regular premium payment protection contract instead of the payment protection contract he bought.*

DISP 3.1.4G
There may also be instances where a firm concludes after investigation that, notwithstanding breaches or failings by the firm, the complainant would nevertheless still have proceeded to buy the payment protection contract he bought.

DISP App 3.6.1E
Where the firm determines that there was a breach or failing, the firm should consider whether the complainant would have bought the payment protection contract in the absence of that breach or failing.

DISP App 3.6.2E
In the absence of evidence to the contrary, the firm should presume that the complainant would not have bought the payment protection contract he bought if the sale was substantially flawed, for example where the firm:

…(4) did not disclose to the complainant, in good time before the sale was concluded, and in a way that was fair, clear and not misleading, the significant exclusions and limitations, i.e. those that would tend to affect the decisions of customers generally to buy the policy;

…(8) did not disclose to the complainant, in good time before the sale was concluded and in a way that was fair, clear and not misleading, the total (not just monthly) cost of the policy separately from any other process (or the basis for calculating it so that the complainant could verify it);

…(10) provided misleading or inaccurate information about the policy to the complainant;

DISP App 3.6.3E

Relevant evidence might include the complainant's demands, needs and intentions at the time of the sale and any other relevant evidence, including any testimony by the complainant about his reasons at the time of the sale for purchasing the payment protection contract.

Overall

61. Taking the relevant considerations into account, it seems to me that the overarching questions I need to consider in deciding what is in my opinion fair and reasonable in all the circumstances of this complaint, are:

- If the firm gave advice, whether it advised Mr F with reasonable care and skill – in particular, whether the policy was appropriate or 'suitable' for him, given his needs and circumstances.

- Whether the firm gave Mr F sufficient, appropriate and timely information to enable him to make an informed choice about whether to take out the policy, including drawing to his attention and highlighting – in a clear, fair and not misleading way – the main provisions of the policy and significant limitations and exclusions.

- If, having considered these questions, I determine the complaint in favour of Mr F, I must then go on to consider whether and to what extent Mr F suffered loss or damage and what I consider would amount to fair compensation for that loss or damage.

62. Mr F says the firm ought fairly and reasonably to have gone further than I have suggested when providing information. I shall address Mr F's representations about this later on.

63. The firm has suggested these overarching questions incorrectly draw upon the wording of subsequent regulatory requirements such as the FCA Principles for Businesses. I do not agree.

64. I accept the FCA's Principles for Businesses place similar requirements on businesses carrying on regulated activities to the overarching questions I have set out here. But, for the reasons I have explained, the Principles for Businesses do not apply to this complaint and I have not taken them into account. Rather, I have distilled the overarching questions from the various relevant considerations which do apply, which I have set out above.

b) the sale - what actually happened?

65. Not surprisingly given the passage of time since Mr F took out the policy, it is not entirely certain how he came to take out the policy and what information or advice (if any) the firm gave him about it.

66. During the course of the complaint Mr F has submitted four payment protection insurance questionnaires setting out his recollections of what happened:

- When he first complained, the representative sent the firm a questionnaire (PPQ 1) which it said had been completed following a detailed discussion with Mr F to establish the true substance of the claim.

- When he referred the complaint to this office following the firm's final response, he completed and signed a second questionnaire (PPIQ 2).

- Prior to our adjudicator's provisional assessment, the representative provided a copy of a further questionnaire (PPIQ 3), which appears to be a copy of PPIQ 1 (so I will refer only to PPQ 1 going forward).

- Following the adjudicator's provisional assessment, the representative submitted an updated questionnaire (PPIQ 4) which it said contained additional information having clarified matters with Mr F.

67. I note that Mr F's representations about what happened have, quite understandably, evolved over the course of the complaint, perhaps reflecting the struggle many consumers would have to recall, in the detail aspired to by the complaints process, events linked to a credit card application a decade and a half ago – something Mr F may have paid only brief and passing attention to at the time.

68. So for example, so far as it relates to the question of how he came to take out the policy, I note that:

- In PPIQ 1, he said the policy was sold during a telephone conversation, he did not receive any documentation about the PPI policy after the sale, and he referred to the omissions of 'the advisor'. He also said that he was not aware of the policy at the time.

- In PPIQ 2, he said he applied by post. There was no mention of a phone call, but he still referred to the role of the advisor and said he was not aware of the policy at the time.

- In PPIQ 4, he said the policy was sold, by post, following a letter he was sent and that he did not receive any printed information or paperwork about the PPI policy after the sale.

69. I also note that more recently, in a statement of facts and grounds, Mr F has provided a more detailed account about what happened, in effect combining his earlier representations:

> *9. The claimant* [Mr F] *had a telephone conversation with the firm about applying for one of their credit cards during which there was a discussion about PPI although the firm did not inform the claimant about any of the exclusions or limitations, or provide him with any information about the cost, during that conversation.*
>
> *10. Following that telephone conversation, the firm sent the claimant a Request Form, to enable him formally to request a credit card. The Request Form also provided for the claimant to apply for PPI, which he did. The only information provided by the firm about PPI, on the request form was…*[the information about the policy on the Priority Request Form].
>
> *11. The firm did not provide the claimant with any further documentation or information about the PPI.*

70. The firm is also not sure about what happened. It says that:

- It does not have a record of a telephone call from Mr F, although it accepts it wouldn't now have a record of it anyway.

- Mr F would either have picked up or received a paper application form, which included Credit Card Terms and Conditions, which included a section: 'Payment Protection Information – What you need to know'.

- It would have sent the full terms and conditions (the Certificate of Insurance) after it processed the application.

71. The firm has provided: a copy of the actual application form Mr F signed – the Priority Request Form; a document headed 'Financial and Related Conditions' (which refers to the firm's credit card terms and conditions); and a section of the Credit Card Terms and Conditions leaflet which contained information about the payment protection cover, both of which it says would have been included in an application of the type completed by Mr F.

72. The Priority Request Form Mr F completed said that *'to accept our Invitation please complete the Priority Request Form using block capitals and tick and sign where appropriate. Then fold and return your completed Request Form to the firm in the envelope provided. No stamp is needed. Applicants must be aged 18 or over.'*

73. The Priority Request Form did not mention the Financial and Related Conditions or the Credit Card Terms and Conditions leaflet (or the information about PPI found at the end of that leaflet.)

74. The Credit Card Terms and Conditions leaflet the firm has provided included the following information about payment protection cover:

HOW DOES PAYMENT PROTECTION WORK?

How Do I Qualify For Cover?

Provided you are the account holder you can apply for insurance if, at the start of your cover, you are: over 18 and not more than 64, in full-time work, including self-employment (of at least 16 hours per week), and not aware of any impending unemployment.

WHAT IS COVERED?

Unemployment, Disability, Hospitalisation

One monthly benefit is payable if: You are DISABLED for more than 30 days and for each period of 30 days thereafter. These will continue until your claim ceases or a total of 24 monthly benefits have been made.

You are UNEMPLOYED as a result of redundancy (not applicable to self-employed) for more than 30 days and for each 30 days thereafter. These will continue until your claim ceases or a total of 12 monthly benefits have been made.

You are confined to HOSPITAL (only applicable to self-employed) for more than 7 days and for each 15 days thereafter. These will continue until you come out of hospital or your claim ceases or a total of 24 monthly benefits have been made.

Life Cover

In the event of death the insurers will pay the outstanding balance on your account, up to a maximum of £15,000.

WHAT ISN'T COVERED?

Payment Protection offers a wide range of benefits at low cost. The principal exclusions are:

Disability, Hospitalisation or Redundancy resulting from war or similar risks; radioactive or nuclear risks; self-inflicted injuries; pregnancy and related conditions; alcohol or drug abuse; or related conditions.

Disability or Hospitalisation resulting from: pre-existing medical condition; conditions occurring whilst outside the UK for more than 60 days; conditions not confirmed by a doctor; backache or related conditions without substantiating evidence; psychotic, psychoneurotic or other mental disorders; cosmetic or beauty treatment unless directly attributable to illness or injury.

Redundancy which occurs within the first 90 days of your insurance; which is normal or seasonal in your job or which you knew to be impending; which follows your refusal of reasonable alternative employment, your own errors or omissions, strike, dispute or lock-out, or the expiry of a fixed-term contract; which is in any way voluntary; or which occurs at a time when you would not ordinarily be expected to work in the UK; unless you were in full-time work for at least 6 consecutive months immediately before you lost your job, and you were not working within a "close company."

This is a summary of cover only. A specimen certificate is available on request and a Certificate of Insurance will be issued to you should you take advantage of payment protection cover. You then have 30 days to cancel cover without charge providing you have not made a claim.

WHAT ELSE SHOULD I KNOW

Monthly benefit: 3% of the outstanding balance on the Agreement at the start of Your Disability or the date of receipt of official notification or Your employment or, £10, whichever is the greater, subject to a maximum of £1,000.

75. I note the payment protection cover information in the extract from the Credit Card Terms and Conditions the firm has provided does not match the terms of the policy set out in the Certificate of Insurance the firm has provided, for example because:

- It says the disability cover was subject to a maximum of 24 payments – the Certificate of Insurance did not.

- It says disability resulting from backache or related conditions would only be covered with substantiating evidence (a term which wasn't defined) – the Certificate of Insurance required radiological evidence of medical abnormality from a doctor.

- It says disability resulting from *"psychotic, psychoneurotic or other mental disorders…"* wasn't covered – the Certificate of Insurance said those things were covered if diagnosed by and requiring a continued course of treatment by a consultant psychiatrist.

- It refers to hospitalisation cover for the self-employed – although that would not have been relevant to Mr F.

76. It is not clear when the Credit Card Terms and Conditions leaflet the firm has provided was first produced or when it ceased to be used – it is not dated.

77. I know from other leaflets I have seen that the firm used different leaflets at different times and the wording changed over time. For example, a leaflet dated July 1999 more closely resembles the policy terms and conditions set out in the Certificate of Insurance. So it is possible the firm may have used a different leaflet in 1998, which matched the Certificate of Insurance, but I have not been presented with persuasive evidence of that. It is also possible that the Certificate of Insurance the firm believes was used in September 1998 is actually from a different time.

78. I also note the firm's submissions made in response to the Provisional Decision that it's possible Mr F received different information. I accept that it is possible that Mr F received different information to the information I have concluded he received, but the example application form (with Credit Card Terms and Conditions attached) the firm has now provided is very different to the Priority Request Form Mr F completed and there is no evidence to suggest Mr F received the example application the firm has now provided before taking out the policy. Overall the firm's further submissions do not persuade me to reach a different view about the documentation Mr F received.

79. Having considered the representations of both sides and keeping in mind the limitations I have highlighted about the evidence from both parties on this point, I find:

- Whilst it is possible Mr F triggered the credit card application process by telephone, it is more likely that Mr F simply responded to the firm mailing invitation.

- Even if it were the case that Mr F prompted the firm to send him the Priority Request Form by calling them, I'm not persuaded it's more likely than not that the conversation involved a discussion about payment protection insurance. I am satisfied this was a sale by paper.

- The Priority Request Form was part of a pack which included the 'Financial and Related Conditions', the Credit Card Terms and Conditions leaflet, including a section headed *'HOW DOES PAYMENT PROTECTION WORK?'* containing the information, or similar information, to what I have set out above.

- It is more likely than not that the firm did send the Certificate of Insurance to Mr F after it approved his card application – quite probably with other documents relating to the card, even though Mr F does not recall that now and that would not have played a part in his decision to apply for the policy, so it's of little consequence to the sale (other than to clarify what Mr F bought).

- It is more likely than not that the policy terms and conditions were those set out in the Certificate of Insurance, although I accept it is possible (but less likely than not) that they might actually have matched the information set out in Credit Card Terms and Conditions leaflet the firm has provided.

c) agency

80. I note the statement in the Certificate of Insurance that the firm was arranging the policy as agent for the insurers. It's possible this might mean Mr F has the option of making the complaint against the insurers instead of the firm.

81. But the fact the firm was acting for the insurers was not disclosed to Mr F at the point he made the decision to take out the policy and the firm accepts responsibility for the sale. In those circumstances I am satisfied that it is appropriate for me to consider the complaint against the firm.

d) did things happen as they should in 1998?

82. I have found that the information the firm gave Mr F about the policy was set out in the Priority Request Form and the Credit Card Terms and Conditions.

83. Whilst I am satisfied the firm also sent the full policy conditions to Mr F after the event, which it was required to do, I do not consider that means the firm gave Mr F the information he fairly and reasonably needed to make an informed decision about whether to take out the policy. I am mindful:

- Mr F did not base his decision to take out the policy on the Certificate of Insurance.

- Mr F was not forewarned in the Priority Request Form that he would receive the document and should not make a final decision about taking out the policy until he had considered it.

- It was incumbent on the firm to provide him with the most important information he required to make his decision before he took out the policy (see the 1996 ABI Statement of Practice for PPI) and full conditions later.

84. Having considered all of the information including Mr F's further representations made in response to the Provisional Decision, I am not persuaded the information the firm gave Mr F could reasonably be considered to amount to advice. I have not seen anything which persuades me that the firm recommended he take out the policy, rather it alerted Mr F to the fact that he could take out the policy and gave Mr F information about it.

85. I note when reaching the conclusion the firm did not give advice, that there is a letter on file which the firm says it sent Mr F in 2003, when it appears the terms of the policy changed, in which the firm said it '*recommended Payment Protection Cover to all our customers'*. But that letter was sent some years after the sale and the firm did not recommend the policy in the literature I am satisfied Mr F was given, irrespective of what it later wrote in 2003. And I am not persuaded to reach a different view by Mr F's representations in response to the Provisional Decision about the 2003 letter.

86. The question I need to consider is in essence (as I set out at paragraph 61 above) whether the firm provided Mr F with sufficient information in an appropriate and timely way to enable him to make a properly informed decision about whether to take out the policy.

87. For the reasons I shall explain, I do not think it did. Exactly how, and the extent to which, the firm fell short of what was reasonably expected of it and its relevance to Mr F, is in my view important to my consideration of the question which ultimately lies at the heart of this complaint: would Mr F have acted differently if the firm had explained things properly?

88. The Priority Request Form invited Mr F to indicate whether or not he wanted payment protection cover. It said:

> *"You can safeguard your payments against the effects of life's unpredictable events with our Payment Protection Cover. Premiums are calculated each month at just 68p per £100 of your statement balance, protecting your payments should you become unable to work due to accident, sickness or unemployment. Life cover is also included, paying off your balance up to £15,000. You should be eligible for cover if you are aged 18 to 64, employed and not aware of any impending unemployment. If*

you'd like to take advantage of this valuable, low cost, peace of mind, just tick the Yes box."

89. I am satisfied this would have been sufficient to make Mr F aware that he had a choice about whether or not to take out the policy – in other words, that the policy was optional and that he explicitly agreed to the policy without undue pressure.

90. This information would also have given him a broad sense of what the policy covered – but by no means all of the information he needed to make a properly informed choice. For example, I am satisfied he ought reasonably to have understood:

- There was an upper agreed limit for taking out the policy, which he met.

- The policy premium was 68p pence per £100 of statement balance and that he would have to pay that each month. But it did not make clear that he would have to make payments during a claim (although it did not suggest he wouldn't have to either), or – as Mr F has reiterated in his response to the Provisional Decision – that the payments would be added to the account balance attracting interest if unpaid at the end of the month.

- The policy included life cover which would pay off his 'balance' up to £15,000. He knew all he needed to know about that.

- The policy would meet his 'payments' (rather than pay off his 'balance' like the life cover) if he was unable to work because of accident, sickness or unemployment. But he would not have understood from this that it would pay out a fixed monthly amount of 3% of the outstanding balance at the start of the claim, that the unemployment cover was limited to twelve payments, nor would he have known what exclusions and limitations on cover there were.

91. Importantly, the Priority Request Form did not encourage or direct Mr F to the section in the Credit Card Terms and Conditions leaflet where he could learn more about the important features of the policy, nor did the 'Financial and Related Conditions' document. That document summarised some of the key credit card conditions, but did not say anything about the policy.

92. I have found that Mr F would also have been given the Credit Card Terms and Conditions where there was further information about the policy, albeit at the end of a lengthy and dense leaflet of terms and conditions predominantly relating to the credit card.

93. If Mr F had looked at the payment protection cover section of the Credit Card Terms and Conditions and considered the information set out there carefully, I'm satisfied he ought reasonably to have known, in addition to the information on the Priority Request Form, much of what he needed to know about the essential features of the cover provided by the policy, the benefits payable under the policy and the significant limitations and exclusions.

94. In other words, having considered the Credit Card Terms and Conditions leaflet, I am satisfied the firm gave Mr F much, but not all, of the missing information he needed to know to make an informed choice.

95. I think it is likely that the firm included the information about the cover provided and things like the significant restrictions on disability cover, in the Credit Card Terms and Conditions, because that was the kind of information it was required to draw to the customer's attention by the ABI Code (and to include in a summary of cover – see paragraph 46 above), which it had undertaken to comply with.

96. But I am not persuaded it did enough to present that information in a way that was fair and reasonable to Mr F. I am not persuaded that the firm did enough to draw the important information set out at the end of the Credit Card Terms and Conditions leaflet to Mr F's attention. It did not present the important information in a clear and appropriate way.

97. I am mindful that this was a sale by paper – Mr F was making his decision about whether to take out both the card and the policy solely on the information he was given. So I consider it is reasonable to expect Mr F to have given greater consideration to that paperwork than if, for example, a policy had been sold during face to face discussions in a branch, or by telephone, where the consumer had relied on what they were told during those conversations.

98. But the onus in this process was on the firm to draw the important information to Mr F's attention – that is the information about the nature and extent of the cover provided that would be relevant to his decision about whether to take out the policy.

99. I don't think the firm did enough to do that, or that Mr F ought reasonably to have scoured the Credit Card Terms and Conditions leaflet looking for more information about the policy, without prompting.

100. In my experience very few credit card customers read and absorb all of the Credit Card Terms and Conditions. And I note some of the more important credit card information was set out in the Financial and Related Conditions document which summarised things in a shorter and more manageable format (but didn't contain any information about the policy).

101. Given it was unlikely applicants would read all of the credit card conditions and the fact that the important payment protection information was not readily identifiable within them, I do not think the firm did enough to draw Mr F's attention to the important information set out there, including limits to the cover provided by the policy. I also think it is unlikely that Mr F would have read them himself without any prompting to do so from the firm.

102. In reaching these conclusions, I am mindful of the representations made by the firm that it did all it was legally required to do by providing the information to Mr F – it says it did not have to go further and says Mr F ought to have read the terms and conditions. Whilst I am mindful of the firm's view, I am satisfied the standards of good practice established by the various ABI publications and ordinary dealings with consumers meant the firm ought fairly and reasonably to have done more than it did to draw the important information about the policy to Mr F's attention.

103. Mr F says he was not given the Credit Card Terms and Conditions. Whilst I note what he says, I think it is likely he is mistaken in his recollection (as I have already found). But having considered these things, I consider it fair and reasonable to conclude on the balance of probabilities that it is unlikely he identified and read the information about the policy found in the Credit Card Terms and Conditions leaflet.

104. I have considered how my findings interact with the FCA's list of significant failings in its guidance for firms handling PPI complaints set out at DISP App 3.

105. It seems to me that it would be reasonable to conclude that there were significant failings in this case. The firm did not for example disclose to Mr F before the sale was concluded and in a way that was clear, fair and not misleading the significant limitations and exclusions that would tend to affect the decision of customers generally to take out the policy [DISP App 3.6.2E(4)].

106. As I have already indicated, I am satisfied the firm provided the information – that information appeared in the Priority Request Form and Credit Card Terms and Conditions. But I am not persuaded the firm presented the information in a way that was clear, fair and not misleading.

107. It is also arguable that the firm failed to disclose the costs information envisaged at DISP App 3.6.2E (8). The firm did disclose how the premium was calculated on the Priority Request Form – a very important piece of information. But it could have made clearer the fact that he would continue to be charged premiums during the claim and the fact the premiums would attract interest.

108. I have considered carefully Mr F's arguments that the firm should have done more than I have found it should have done and provided additional information. I have given particular thought to Mr F's view that the common law duty of utmost good faith meant that:

- The firm should have explained the low claims ratio (and what he considers to be the inherent poor value) and the fact much of the premium went to the firm rather than the insurer.

- The firm should have told him not just about the limitations and exclusions, but also about the significance of them.

But having done so, I am not persuaded by Mr F's views in that regard.

109. Under the law which existed at the time, both parties to an insurance contract owed a duty of utmost good faith to the other. By way of summary only, both parties had duties to disclose material facts and to refrain from making material misrepresentations to the other.

110. Usually, the focus of any dispute tends to be on the extent of the obligations the duty of utmost good faith places on the person seeking insurance to disclose to the insurer the information it needs to determine and calculate the risk it will be taking if it agrees to provide the insurance.

111. But an insurer also has a duty to disclose:

> *..all facts known to him which are material either to the nature of the risk sought to be covered or the recoverability of a claim under the policy which a prudent insured would take into account in deciding whether or not to place the risk for which he seeks cover with that insurer.*[4]

112. MacGillivray on Insurance Law[5] explains that the duty does not extend to giving the insured the benefit of the insurer's market experience, such as for instance, that the same risk could be covered for a lower premium either by another insurer or, presumably, by the same insurer under a different type of insurance contract; and the insurer is not required to perform the role of the insured's broker in this regard.

113. I cannot be certain, but I think it is unlikely a court would conclude an insurer should have disclosed the claims ratio and 'value' information, or contextualised the information about the limitations on disability cover in the way Mr F says the firm should have done by virtue of the duty of utmost good faith. In any event, I do not think it would be fair or reasonable in the circumstances of this case to impose such requirements on the firm. I note that in response to the Provisional Decision, Mr F considers this to misstate the legal position. I do not agree with this representation.

114. The firm was not the insurer in this transaction – although as I have already discussed, it was said to be the agent of the insurer. Regardless, the ABI Code also referred to an overriding duty on the intermediary to act with utmost good faith and integrity.

115. The Guidance Notes for Intermediaries and the Resume for Intermediaries about the application of the ABI Code which I have referred to in this decision do not refer to that duty or elaborate on what it was intended to mean. But I think it is unlikely that it was intended to place a greater or substantially different, obligation on the intermediary to that owed by the insurer.

116. I consider it more likely than not that the reference to an overriding duty on the intermediary was a reminder of the importance of disclosing material information to both the insurer and the insured (depending on whom the intermediary was acting for), reflecting the legal duty those parties were under. And it seems likely the provisions of the ABI Code were in effect intended to be practical examples of how the intermediary might meet the overarching principles of utmost good faith and integrity as well as expected standards of good practice.

117. I also note there was no expectation at the time under the provisions of the ABI Code that insurers or intermediaries should proactively disclose commission – for example, the guidance to the ABI Code published in December 1994 said only that independent intermediaries should disclose commission on request.

118. Nor do I consider it can reasonably be inferred from the ABI Statement of Practice for Payment Protection Insurance (which gave further information about the expectations in PPI sales) that insurers or intermediaries were expected to disclose the kind of information Mr F says the firm should have done.

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[4] *Banque Keyser Ullmann SA v Skandia (U.K.) Insurance Co. Ltd [1990] 1Q.B. 665, 772*
[5] MacGillivray on Insurance Law 13th edition 17-094

119. So it seems very unlikely that it was ever the intention of the ABI Code that intermediaries should provide the kind of additional information Mr F suggests it should. In any event, I am not of the view that it would be fair and reasonable in the circumstances of the case to impose a greater or substantially different, obligation on the intermediary to that owed by the insurer.

120. Overall, taking into account the law, industry codes and standards of good practice applicable to this complaint, I am not persuaded that the firm ought fairly and reasonably to have provided the additional information Mr F says it should have done.

121. I also note Mr F's view that the following statements in the Priority Request Form misrepresented the terms of the policy:

- *'premiums are calculated each month at just 68p per £100 of your statement balance'* – essentially because the premiums would attract interest like other payments made on the card.

- *'protecting your payments should you become unable to work due to accident, sickness or unemployment'* – essentially because there were significant limitations on when the policy would pay out and on the period of cover.

- *'If you'd like to take advantage of this valuable, low cost, peace of mind, just tick the Yes box'* – essentially because in Mr F's view and that of his representative, the policy provided poor value.

122. But I am mindful that:

- I have found Mr F was also given, at the same time, information about the limitations and period of cover in the Credit Card Terms and Conditions – as the firm has pointed out, a court when considering a misrepresentation claim would ordinarily look at all of the information he was given.

- The premiums *were* calculated in the way the firm represented. The issue in this case is that Mr F may not have made the link between that information and the other information he was given about the credit card to realise the policy premiums would attract interest if unpaid.

- As my calculation shows, the policy would more than cover the contractual payment and the PPI costs added to the policy during the period of a claim and the interest associated with it. Whilst there were limitations on cover, the policy did provide cover in a variety of circumstances.

123. Whilst I accept there is a possibility a court might conclude these statements mis-represented the contract, in my opinion the reason why the firm failed to act fairly and reasonably was not because of what the firm said or didn't say in the Priority Request Form, but because the overall information the firm gave Mr F, in the way it did, was insufficient to meet the standards I consider it fair and reasonable to expect it to have met, in 1998, when providing information about an insurance policy.

124. Overall, for the reasons and in the ways I have set out, I find the information the firm gave Mr F, in the way it did, was insufficient and presented the policy in an unbalanced way.

125. In particular, the firm failed to draw Mr F's attention in a clear and fair way to the important information about the policy in the Credit Card Terms and Conditions, and so the information Mr F based his decision on was ultimately misleading. It could also have made clearer the fact that the premiums charged would attract interest and that Mr F would continue to be charged premiums during a claim. I am not persuaded these shortcomings were fair and reasonable in all the circumstances.

e) what effect did the firm's shortcomings have on Mr F? to what extent did Mr F suffer loss or damage as a result?

126. I have found the firm did not do all it should fairly and reasonably have done when it sold this policy to Mr F, so I have gone on to consider whether it would be fair and reasonable to conclude Mr F suffered loss and damage as a result.

127. It seems to me that whether or not Mr F has suffered loss or damage in this case depends on whether, if the firm had explained things properly, Mr F would have acted differently, or whether he would have taken out the policy in any event?

128. Mr F says he would not have taken out the policy and I should, in any event, presume that he would not have taken it out given the substantial failings in the sales process I have identified (unless the firm can produce evidence to show he would have taken out the policy, which Mr F says it cannot because its failings were so fundamental).

129. Mr F also says that a court would take a different approach if it were to find there were misrepresentations. For example, Mr F's representative, cited certain selected passages from *Raiffeisen v RBS* [2010] EWHC 1392 (Comm) in its letter of 31 July 2017:

*'However, even if the misrepresentations had been merely negligent or innocent, the correct test for rescission in misrepresentation is not: "what would the innocent party have done if he had been told the truth?" (FOS's approach) but: "were the misrepresentations a real/substantial cause of the innocent party entering into the contract at all/in those terms, even if there were other causes, such that but for the misrepresentation the innocent party would probably not have entered into the contract/in those terms?" (**Raiffeisen-v-RBS** [2010] EWHC 1392 Comm ("**Raiffeisen**"), at 153-191).*

*In particular, in the misrepresentation context, it is irrelevant to ask how the innocent party would have acted if the misrepresentations had not been made (**Raiffeisen** at 186-190).'*

130. The firm says Mr F would still have taken out the policy because:

- Mr F was financially stretched and had no other means to pay his debts if he couldn't work – he had a real need for payment protection insurance.

- It was not unusual or unexpected for policies to exclude pre-existing medical conditions and to require medical evidence to evidence medical conditions such as stress. Mr F would not have thought it unreasonable at the time.

- The disability cover applied if Mr F became unable to carry out his existing work or any other reasonable work – that did not mean the insurer would decline a claim by saying Mr F could get another job. Provided he was unable to work for a sufficient period the policy would pay.

- It was not unusual for the policy not to apply for the first 30 days of unemployment or disability cover – it is likely for example that Mr F could have claimed sick pay for the first 30 days. And the policy provided valuable cover – he could claim as much as £1,000 per month on the disability cover for an extended period of time.

- It was not unreasonable for Mr F to continue paying premiums during the claim – the policy was designed to cover the debt repayment and the premium in the event of a claim.

- The policy provided life cover to repay the whole debt in the event of his death and the price was affordable.

131. I have considered the representations of both sides and the evidence relating to this carefully.

132. Taking out insurance like this, based only on information, requires the consumer to weigh up a number of factors before deciding whether to proceed. PPI policies typically provide cover in a variety of situations, some of which may be of greater interest or relevance to the consumer than others.

133. Effectively the consumer has to weigh up in their own minds the cost of the policy against the benefits offered in return and the potential consequences they will suffer if they do not have insurance should the risks come to fruition. That is why it was incumbent on the intermediary to provide the information about the policy's features, so the consumer could make that assessment.

134. The evidence in this case suggests that Mr F clearly had some interest in taking out payment protection insurance. In saying that, I do not mean he actively sought insurance or that it was his intention to take out insurance before he applied for the credit card – I have seen nothing to suggest he did.

135. Rather, I mean when the firm told him – on the Priority Request Form – that there was a product he could buy that would both protect his credit card payments in the event that he was unable to work because of accident, sickness or unemployment and which would pay off his entire balance if he died, that resonated with him in some way and he concluded that he wanted that product.

136. The issue here is that the decision he made was based on incomplete information, meaning what he thought he was getting is not exactly what he got. And he would have had different things to weigh up when deciding to take out the policy if the firm had provided the information in an appropriate way.

137. I consider that in deciding what is fair and reasonable in this case and whether Mr F suffered loss or damage as a result, the evidence about the extent to which the product differed from what Mr F might reasonably have expected from what he was told, is relevant to the consideration of what would have happened.

138. In this case, the evidence about Mr F's circumstances at the time of sale shows that the policy was not fundamentally wrong or unsuitable for him. He was eligible for its benefits (at least for the next 8 years) and it provided cover that could prove valuable to him should the insured risks come to fruition – even allowing for the limitations on the disability cover it provided.

139. Mr F's own evidence or 'testimony' is that if he had lost his job through accident, sickness or redundancy, he wouldn't have any way of meeting his credit card payments. And in fact he had some problems meeting the payments whilst he was working, falling into arrears at times.

140. As I have explained earlier in the decision, I think Mr F is in part wrong about his position should he not be able to work for redundancy related reasons. But given his representations, it does not appear that was something Mr F would have thought about when taking out the policy (and it was not an advised sale, so it was not for the firm to do the thinking for him).

141. I think it is reasonable to conclude that from Mr F's perspective he saw considerable benefit in having insurance. If the risk the policy was concerned about came to fruition, he would have had difficulties managing the consequences if he did not have insurance. In other words, his view was that he would have had a problem making the payments in the circumstances the policy appeared to cover.

142. It also seems likely that he intended to transfer £2,000 of existing debt to the account from the outset (which is what he did) so that may also have factored into his thinking.

143. Whilst Mr F was interested in the policy, was eligible and had good reason for wanting cover, the policy did not work entirely as he thought.

144. In relation to the costs, the firm did tell him about an important part of the costs information – that the premium cost 68p per £100 of outstanding balance each month.

145. But as Mr F says, the firm did not explain in terms that he would continue to be charged for the policy in the event of a claim, or spell out that that the premiums were added to the account balance (so would attract interest). As the firm has pointed out though, there was no suggestion the premiums would be paid in some other way and they appeared on his statements, so it's possible Mr F might have expected this.

146. In addition, it didn't make clear what he would get back in return in the event he made a successful claim – the Priority Request Form didn't explain the 3% benefit calculation.

147. The information Mr F relied upon said that the policy would safeguard his monthly payments. Mr F could have interpreted that in a number of ways, but it seems unlikely that he would have thought that meant it would pay off his balance (unlike the life cover) and I think it's more likely he would have understood from the information in the Priority Request Form that the policy would meet the minimum contractual monthly payment in the event he made a claim.

148. As the example I set out earlier in this decision illustrates, the policy would more than cover the minimum contractual payment and the PPI costs added to the policy during the period of the claim and the interest associated with it.

149. So, whilst Mr F didn't know some things, the ultimate position in the event of a successful claim was not dissimilar to what he would reasonably have thought from the information he based his decision to take out the policy on and found acceptable.

150. Possibly the most significant differences between what Mr F thought he had bought and what he had actually bought were the limitations on back and mental health claims.

151. The terms of the policy also differed from what Mr F might have expected because he would only be eligible for disability cover if he was unable to do both his own job and a reasonable alternative and, as I have previously explained, there were limits on the period of an unemployment claim.

152. Mr F has provided information in PPIQ 4 about what he would have done with more information, which I have considered carefully. He says:

> *The firm did not explain how much this PPI was really going to cost. They also did not explain how little of the amount I would have to pay would actually be used to provide any kind of insurance and how much was just being taken for profits or being used to pay commission. I still do not know exactly how much this has cost me and my representative have told me that I have a right to know, now. However, my representative have explained that with credit card PPI, the normal cost is at least 8.5% of the balance every year and that if this is added to your balance it 'compounds'. On top of this, interest is charged on your balance at credit card rates of interest and that this means that over 10 years this could even treble your initial balance. They say that the exact effect depends on your circumstances and how long you have the card for and so on, but the important point is that, although credit card PPI was presented as being cheap, it was really extremely expensive. The firm never gave any indication at all of how expensive credit card PPI could be or of what it could really cost. My representative have also explained that as much as 86% of the PPI premiums and all the interest was going to the firm for profits and commissions and so on, rather than to pay for insurance. So this means that rather than being used to insure me the firm were just keeping most of my money for themselves. If I had known this I would not have wanted this PPI. It is plain from this that the PPI was really expensive because it was being sold for a lot more than it was really worth. I was not even told about this and I do not think this was fair. This PPI was expensive and bad value and I would obviously not have wanted it [had I] known this at the time.*
>
> *My representative say the firm had to explain the exclusions and limitations, in a way that an ordinary person like me would have understood. I can definitely say the firm did not do this. My representative have explained to me that the majority of reasons you were likely to miss work were excluded - in particular stress and bad backs - which are the most common reasons people miss work and on their own cut out more than half potential claims. If the firm had said that they were excluding the most common reasons people miss work I would not have wanted this PPI for that reason alone. My representative have pointed out this just makes it obvious that the PPI was never going to do what it was supposed to be for. It was supposed to protect*

payments if you couldn't work, but wouldn't have done that in a huge proportion of cases.

As well as everything else, I was financially stretched. In fact I have struggled to pay my debts and gone into arrears. My representative says that for me, even more than anybody else, it was wrong for me to spend money on this PPI which was both really expensive, and unlikely to pay out.

I don't think this PPI should have been sold to me and I would not have wanted it if it had been properly explained. My representative say that the firm were supposed to treat me fairly and not take advantage of me, but it cannot be right to sell a product like this PPI without explaining the costs and exclusions, and keep so much money for something with so little value to me. I feel let down by the firm.

153. Mr F is effectively saying that as a result of what his representative has told him, both about what it considers should have happened and what he should have decided at the time, he would not have taken out the policy.

154. In light of the findings I have already made, I don't think Mr F's representations demonstrate what he claims because much of the information he says would have affected his decision would not have been known to him at the time of sale, even if everything had happened as it should. For example:

- There was no legal, code, or good practice requirement on the firm to disclose the commission it received.

- I am satisfied the requirement on the firm in 1998 was to draw his attention to the limitations, not to give the limitations the context Mr F says the firm should have given them.

155. I am also mindful that: Mr F's recollections of the sale are, owing to the significant passage of time, likely to be limited; his representations about what he would have done are made in support of a claim for compensation; and the paragraphs I have quoted resemble quite closely the consumer representations made in other cases where this representative represents the consumer.

156. But I do accept the limitations on the disability cover provided by the policy might well have given Mr F pause for thought – as Mr F says, these are common conditions.

157. Whilst it is likely he would have expected to provide some medical evidence to support a claim arising from a back condition or mental health condition (as the policy required for other conditions), the steps required for these conditions were more onerous than he might reasonably have expected (which is ultimately why the firm needed to draw them to his attention).

158. I accept Mr F may well have concluded that the policy was not as good as he thought and he might have decided not to proceed. This limitation on cover, when coupled with the other shortcomings in this sale, might have dissuaded many consumers in slightly different circumstances from Mr F from taking out the policy.

159. But Mr F, in his circumstances, still had some good reasons to take out the policy, notwithstanding the reduced value of the policy compared to what he would have expected from the information he was given.

160. I consider it fair and reasonable to think Mr F would have weighed up the various other considerations, in particular his view that he did not have other means of meeting his payments in the event he lost his job. It is likely he would also have thought about whether the cost to benefit proposition still worked for him – particularly as money was tight.

161. Having considered all of the evidence and arguments in this case I consider it more likely than not that that Mr F would still have taken out the policy. The policy was sufficiently close to what he thought he was getting and Mr F did not have any means of meeting his card payments if he was unable to work as a result of sickness or accident and, he thought, redundancy. And in those circumstances I consider it more likely than not that he would have taken out the policy in any event.

162. I have considered Mr F's representations about causation and DISP App 3, including the general opinion of the representative's legal advisor on behalf of Mr F and the further representations it has made about this issue in response to the Provisional Decision. That guidance is for firms, but it is a relevant consideration I take it into account along with many other things when I decide what is in my opinion fair and reasonable.

163. I am mindful of the purpose of the guidance. I don't think it was ever intended to be at odds with the approach I have taken. FSA explained its thinking in the policy statement[6] at the time:

> *…we have taken as a starting point the typical approach in law (which we understand also to be the FOS's general approach) that the customer should be put in the position they would have been in if there had been no failure to comply with its obligations on the part of the firm. Typically that involves considering what the customer would have done 'but for' the firm's breach or failing. Firms have also been making such 'but for' judgements for many years, it being the basic tenet of complaint handling. Complaints about PPI are not new or unusual in this respect. We are satisfied that the 'but for' test is a reasonable one in the circumstances.*
>
> *The presumptions represent a way of judging what a customer would generally have done, in our view. Having given due consideration to responses concerning presumptions we remain of the view that the presumptions we have set out are reasonable ones fully in the tradition of, and informed by, the kinds of judgements that courts and ombudsmen have long and often been making when assessing claims and complaints and the potential need to put the claimant, as far as practicable, back in the position 'they would have been in' had the breach not occurred.*
>
> *We also recognise that it would not be possible to establish in every case what a customer would have done in every individual circumstance and that there has to be*

[6] Financial Services Authority Policy Statement 10/12 The assessment and redress of Payment Protection Insurance complaints – Feedback on the further consultation in CP 10/6 and final Handbook text – page 43 - 45

scope for a firm to depart from the presumptions. So, the presumptions are rebuttable – that is, it is open to the firm to evidence that the customer would have bought the policy notwithstanding the breach or failing, in which case no redress will then be required.

164. It also said:

A recording of the sale is not essential to rebut the presumptions. Where it is not available, firms must fairly assess the available evidence to make a decision about what they think would likely have happened, but for the failing, given the circumstances and the evidence from the sale. For example, if the firm failed to disclose the existence of an exclusion relating to pre-existing medical conditions, then it may be reasonable for the firm to rebut the presumption that the customer would not have bought the policy if it can be shown that the customer did not have a pre-existing medical condition. It is unlikely that a recording of the sale would illicit this information. The PPIQ, if properly completed, will however provide this information.

We have carefully considered, in light of responses, the proposed list of 'substantial flaws' in the proposed Handbook text. We are satisfied that the rebuttable presumptions cover substantial flaws and that our proposals are appropriate because in each case the nature of the failing raises serious doubts over whether the customer would have proceeded with the purchase if there had not been such a failing.

It is true that the presumptions do not make allowance for the materiality of the failings. We consider that the failings amount to substantial flaws irrespective of their materiality to particular consumers, and that it is reasonable and simpler for our guidance not to differentiate the failings in terms of materiality. In practice, firms are likely to be able to factor in considerations of materiality when potentially rebutting the presumptions in the case of a particular complaint. For example if a firm failed to disclose an exclusion, and if that exclusion did not apply to that customer at the time of the sale (something which can be evidenced relatively straightforwardly with reference to the policy), it may be reasonable for the firm to conclude (assuming there are no other failings) that the exclusion was not material to that customer and that he would have bought the policy anyway, notwithstanding the firm's failure to disclose the exclusion…

165. I have thought about what outcome applying the FCA's guidance to this complaint might lead to. In the language of DISP App 3, I have found it would be reasonable to conclude there were substantial flaws in the sales process. In those circumstances, DISP App 3 says it should be presumed Mr F would not have bought the payment protection insurance he bought unless, in the particular circumstances of the complaint, there is evidence to rebut the presumption.

166. I am satisfied, applying DISP App 3, it is reasonable to conclude the presumption is rebutted in the particular facts and circumstances of this complaint. Based on the evidence pertaining to Mr F's circumstances I have considered above I consider it reasonable to conclude the position Mr F found himself in as a result of the sale was the same position he would have been in had the 'breach' or 'significant failings' not occurred. In other words, I am satisfied that Mr F would have bought the policy in the absence of the breach or failing.

167. I am mindful of Mr F's representations that the presumption may only be rebutted when the flaws in the sale process were immaterial, that the flaws in this case were highly material and I have failed to give proper weight to the evidence – including his own representations – that he would not have taken out the policy. However, I am not persuaded by those representations.

168. Even if I am ultimately departing from the guidance for firms set out at DISP App 3 (which I don't consider I am), I am doing so because I do not consider, in this case, that it would represent fair compensation to put Mr F in the position he would have been in if he had not bought the policy.

169. That is because, whilst I accept it is possible that he would not have taken out the policy, I am satisfied that of the two possibilities, it is more likely than not that he would still have taken out the policy if he had been given clear, fair and not misleading information about the policy he was buying.

170. I am satisfied it would not be fair and reasonable in those circumstances to conclude the firm should pay Mr F redress, as that would put him in a better position than he would have been in if everything had happened as it should have done.

171. It follows from my findings that on the balance of probabilities it is more likely than not that Mr F would have taken out the policy if things had happened as they should, that I am not persuaded he has suffered loss or damage as a consequence of the way this policy was sold.

172. I have also carefully considered Mr F's representations about the approach a court might take if (which in my view is by no means certain in this complex area of law) it were to conclude the firm fraudulently or negligently misrepresented the contract to Mr F and about the remedy a court might award if it were to find that the firm had been in breach of its duty of utmost good faith. But they do not persuade me to alter my conclusions about what is fair and reasonable in all the circumstances of the complaint and what is fair compensation in the circumstances of this case. As I have explained above I do not consider it would be fair and reasonable to put Mr F in a better position than if everything had happened as it should have done.

173. I have thought about whether it would be appropriate to make an award of some kind because of the flaws I have identified in the sale process even though I have found Mr F would still have taken out the policy. I have not seen anything in the evidence relating to this case which leads me to conclude that Mr F suffered material distress or inconvenience because of the way the policy was sold or any other form of non-pecuniary financial loss. In those circumstances, I do not consider it would be fair to make an award.

my final decision

174. Overall, having considered all the evidence and arguments to decide what is, in my opinion, fair and reasonable in all the circumstances of this complaint and for the reasons I have set out in detail above, my final decision is that I do not make an award or direction in favour of Mr F.

175. I now ask Mr F to either accept or reject my decision by 9 October 2017.

Richard West
ombudsman